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CNA TRAINING ADVISOR From HCPro

Pain management

Pain affects many nursing home residents. It often results from injury or sensory stimulation. A variety of factors affect recognition, assessment, and management of pain. Likewise, many factors affect the presence, intensity, and ability to describe pain. The inability to communicate does not mean pain is minor or does not exist.

Pain is always a symptom of something wrong. Unrelieved pain has many significant physical and psychological consequences. It interferes with the resident's optimal level of function and self-care. It contributes to **immobility,** increasing the risk of **skin breakdown, contractures, behavior problems, depression,** and many other complications.

This issue will address the **types of pain** that long-term care residents may experience. It will also introduce some of the **medical conditions** that often lead to the development of pain and will describe how CNAs can overcome the challenges of identifying and managing pain in elderly residents.

Have a good day of training, and stay tuned for next month's issue of **CNA Training Advisor,** which will cover caring for bariatric residents.

Identifying pain

Pain is subjective. Because it cannot be seen, CNAs must rely on input from residents in order to identify pain. Not all residents, however, are able to verbally communicate. Thus, CNAs must be able to pick up on non-verbal cues potentially indicating pain. Ask your participants to brainstorm what those cues might be.

PROGRAM PREP

Program time

Approximately 30 minutes

Learning objectives

Participants in this activity will learn how to:

- Identify the various types of pain that affect residents
- Recognize the medical conditions that sometimes lead to the development of pain
- Effectively assist residents suffering from pain
- Overcome common barriers to pain management

Preparation

- Review the material on pp. 2–4
- Duplicate the **CNA Professor** insert for participants
- Gather equipment for participants (e.g., an attendance sheet, pencils, etc.)

Method

1. Place a copy of **CNA Professor** and a pencil at each participant's seat
2. Conduct the questionnaire as a pretest or, if participants' reading skills are limited, as an oral posttest
3. Present the program material
4. Review the questionnaire
5. Discuss the answers

Tips and tools for CNA training

Looking for more information about CNA training? Sign up to receive the **LTC Nursing Assistant Trainer,** a free biweekly e-newsletter that addresses all of your training needs. The **LTC Nursing Assistant Trainer** provides training tips on nursing measures, best practices, and other crucial aspects of job training for CNAs. This free e-newsletter gives you valuable information and tools to help you conduct efficient, innovative training for every CNA in your facility.

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Pain that affects function or quality of life is a significant problem in long-term care facilities, where up to 80% of the residents have one or more painful conditions. In this setting, musculoskeletal conditions and arthritis are the most common causes of pain. Problems associated with conditions of the nervous system, such as shingles and diabetic neuropathy, are also fairly common.

Although pain is often associated with tissue damage, no gauge exists to identify a relationship between tissue damage and prevalence of pain. Tissue damage may be present and not visible, or the resident may have pain that seems out of proportion to the visible area of damage.

There are several categories of pain, but sometimes one problem cannot be differentiated from another, and signs and symptoms often overlap. Residents may have more than one painful condition.

Because of the prevalence of pain in the geriatric population, CNAs should maintain a high level of suspicion related to the potential for, or presence of, pain. This is especially important for cognitively impaired residents with behavior problems, residents who fail to eat, and those who are able but fail to participate in other ADLs, such as dressing, bathing, and ambulating.

Types of pain

Long-term care residents may experience a variety of pain types based on their personal conditions. Those types, and their definitions, are listed below:

- **Acute pain** is pain with an abrupt onset and limited duration that is usually resolved in fewer than six months.
- **Cancer pain** is sometimes listed in other categories. Some experts consider it a subtype of acute pain. If the patient lives long enough, the pain becomes chronic. This is pain associated with a known malignancy. It is difficult to classify and may fall into more than one category, such as neuropathic pain and nociceptive pain.
- **Breakthrough pain** is usually associated with pain that is well controlled; it is a transient, situational, or episodic increase in pain that requires treatment with a rapid-acting medication. This type of pain may also be seen when a drug is wearing off before the next dose is due. If the pain is neuropathic in origin, it may be difficult to predict.
- **Incident pain** is sometimes considered a subtype of breakthrough pain. This is situational or episodic pain that often occurs predictably and is associated with a precipitating event, such as pain on movement or pain associated with a procedure such as wound care.
- **Mixed or unspecified pain** are terms used by some experts to describe pain caused by multiple problems or pain in which the exact cause is unknown, such as severe, recurrent headaches.
- **Nociceptive pain** occurs when receptive nerve endings are damaged or stimulated by touch, pressure, heat, an irritant, etc.
  - Somatic pain is a type of nociceptive pain with origins in the muscles, joints, connective tissue, bones, and skin; this pain is usually localized in one area. The resident may complain of throbbing and/or aching. Pain is usually aggravated by activity and relieved by rest.
  - Visceral pain is a type of nociceptive pain with origins in the internal organs, such as the gallbladder or gastrointestinal tract; it may be well localized or poorly localized, depending on cause.
- **Neuropathic pain** is associated with abnormal processing of sensations by the nervous system; this category may be further subdivided into peripherally and centrally generated pain.
  - Phantom pain is a form of neuropathic pain that may result in burning, tingling, itching, numbness, or pain that seems to originate in a part of the body that has been removed.
- **Persistent pain** (formerly called chronic pain) was renamed because of prevalent stereotyping and negative attitudes associating this type of pain with addiction and drug-seeking behavior. Persistent pain is a legitimate pain that typically persists beyond a three- to six-month period of time, perhaps for life, and is recurrent and of varying intensity. It might not be associated with a known diagnosis. New research suggests that undamaged nerve fibers cause persistent pain. Until recently, researchers believed that damaged nerve fibers were responsible for transmitting pain impulses to the brain. This information is useful in the quest to identify more effective analgesics.
  - Persistent nonmalignant pain (formerly called chronic, nonmalignant pain) is another term for persistent pain. This type of pain is usually associated with a chronic condition or injury rather than a malignancy.
- **Referred pain** travels to another area of the body through shared nerve pathways, such as chest pain radiating to the jaw and arm, and gallbladder pain radiating to the shoulder.

Other definitions to note include:

- Pain threshold—the least stimulus-producing pain
- Pain tolerance—the greatest level of pain a resident can tolerate
- Sensory threshold—the least stimulus a resident can recognize and identify

The development of pain

Numerous disorders and conditions are often associated with the development of pain in long-term care residents. Many tend to predominantly affect older adults, whereas others may cause the development of pain in all age demographics. These conditions include:

- Abnormal functioning of the peripheral or central nervous system
- Amputations
- Arthritis

- Cardiovascular disorders
- Contractures, complications of immobility
- Crystal-induced arthropathies (e.g., gout, pseudogout)
- Degenerative joint disease
- Fibromyalgia
- Fractures
- Gastrointestinal conditions (e.g., constipation, ileus, gastritis, gastroesophageal reflux, peptic ulcers)
- Headaches (e.g., temporal arteritis)
- Low-back disorders
- Metabolic conditions (e.g., electrolyte abnormalities, vitamin D deficiency)
- Musculoskeletal disorders
- Nerve compression
- Neuropathies (e.g., diabetic neuropathy, occipital or trigeminal neuralgia, postherpetic neuralgia)
- Oral or dental pathology
- Osteoporosis (compression fractures)
- Peripheral vascular disease
- Post-stroke syndromes
- Pressure ulcers
- Renal conditions (e.g., bladder distension, infection, kidney stones)
- Rheumatoid arthritis
- Sprains, strains, bumps, bruises, skin tears, and other accidental injuries
- Trauma, inflammation, and metastatic infiltration of skin, soft tissues, or bone

Pain management challenges: Elderly residents

Residents of long-term care facilities have pain, just as people of all age groups do. What makes pain assessment and management challenging with older adults in this setting is that:

- The residents' response to pain and signs and symptoms of pain may differ from that expected of younger adults; signs and symptoms may be atypical for the condition
- Residents may have cognitive and/or communication problems affecting the ability to alert someone to the presence of pain
- Staff members may fail to ask cognitively impaired residents about the presence of pain
- Behavior problems that are usual for the resident may not be associated with pain
- Residents may use different terminology to describe the pain compared with younger persons
- Some residents may not report pain for a variety of reasons
- Assessments, tools, policies, procedures, protocols, and guidelines may be unavailable to assist the staff
- Other illnesses and medications may affect the residents' interpretation of the pain, response to pain, or ability to report pain
- Turnover and staffing problems affect knowledge of each individual resident and time available to observe and assess the residents
- Staff members may be inappropriately trained in recognition, assessment, and management of pain; some nursing schools and textbooks have provided misinformation about pain assessment and management, including promoting the fear of addiction
- The residents often have several chronic diseases and the cause of the pain is difficult to identify
- The residents' bodies react differently to drugs compared with that of younger persons; normal aging changes affect how residents metabolize and eliminate drugs, making them much more sensitive to the therapeutic and toxic effects of analgesics and other medications
- Water is a diluent for medications; many long-term care residents have chronic, mild dehydration, and fluid intake may be inadequate

Pain and depression

Pain and mood disturbances seem to go hand in hand in older adults. Residents with pain may also have feelings of anxiety, depression, apathy, and sleep disturbance.

Fear of the meaning of pain (e.g., worsening of condition, end of life), apprehension, and anxiety can augment the pain response and make coping more difficult. However, avoid thinking that pain is the sole cause of depression and that controlling the pain will eliminate the depression. Depression, if present, must be treated aggressively, or pain management is not likely to be successful.

Several studies have shown that investigating the relationship between depression and pain frequently facilitates treatment for both conditions.

Pain identification and management barriers

One enlightening study found that one-quarter of facility residents with moderate to severe pain receive no analgesic medications on a daily basis. The reasons given are actually barriers that all CNAs can learn from:

- Nurses seldom incorporated formalized pain assessment protocols when they suspected pain. Rather than assessing the residents, nurses used visual and behavioral cues based on their knowledge of each resident.
- CNAs did not report pain because their reports were either ignored or resulted in the nurse admonishing the assistant.
- Pain cues were sometimes masked by resident behaviors, family manipulation, attention-getting behavior, attitudes about pain, and fear of addiction.
- Nurses believed the physician was the most important person involved in meeting residents' pain management needs.
- Researchers noted that formal pain assessment protocols were likely to identify pain missed by nurses.

Barriers to effective pain management exist on many levels, including physician, nurse, nursing assistant, resident, family, and environment. Additional barriers to pain identification and management cited in various studies include:

- Denial
- Cultural, religious, and/or social issues
- Racial, ethnic, and gender stereotyping and biases
- Cognitive impairment
- Fear
- Shame
- Misperceptions
- Belief that pain is a normal aging change
- Language barrier
- Other communication barriers, such as aphasia
- Myths and misinformation about pain
- Family or staff attitude
- Semantics; residents using different words to describe pain
- No specific cause for pain ever identified
- Inadequate communication
- Breakdown in the continuity of care
- Lack of commitment to pain management
- Environmental problems
- Nonspecific symptoms
- Atypical pain response
- Coexisting illnesses and multiple medication use affecting the ability to interpret or report pain
- Multiple medications affecting residents' pain response
- Concern about side effects
- Comorbidities
- Staff knowledge, skill, and training deficits
- Misunderstanding about analgesics, including opioids
- Lack of proper assessment tools
- Lack of time
- Nurses disbelieving resident complaints
- Residents lacking visible signs of pain
- Workload, turnover, and staffing issues
- Staff desensitized to residents with pain
- Belief that pain treatment is unnecessary in light of adequate function
- Belief that persistent pain has little potential for change
- Fear of functional dependence
- Physicians underprescribing medications ■

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PAIN MANAGEMENT

Mark the correct response.

Name: Date:

1. In long-term care settings, _____ and _____ are the most common causes of pain.
   a. fractures; arthritis
   b. musculoskeletal conditions; arthritis
   c. cancer; skin conditions
   d. fractures; HIV/AIDS

2. Because of the prevalence of pain in the geriatric population, CNAs should maintain a high level of suspicion related to the potential for or presence of pain, especially for _____.
   a. cognitively impaired residents
   b. residents who fail to eat
   c. residents who refuse to participate in ADLs
   d. all of the above

3. Pain with an abrupt onset and limited duration that is usually resolved in fewer than six months is known as _____ pain.
   a. acute
   b. cancer
   c. breakthrough
   d. incident

4. _____ pain is associated with abnormal processing of sensations by the nervous system.
   a. Nociceptive
   b. Somatic
   c. Neuropathic
   d. Persistent

5. Sensory threshold is the least stimulus a resident can recognize and identify.
   a. True
   b. False

6. All of the following are disorders or conditions often associated with the development of pain in long-term care residents, except _____.
   a. amputations
   b. nerve compression
   c. anemia
   d. pressure ulcers

7. One of the major challenges of managing pain in elderly residents is that they often have several chronic diseases and the cause of the pain is difficult to identify.
   a. True
   b. False

8. Elderly residents' bodies react differently to drugs compared with that of younger individuals, which makes them _____ sensitive to the therapeutic and toxic effects of analgesics and other medications.
   a. much less
   b. less
   c. more
   d. much more

9. Pain and mood disturbances are completely unrelated, especially in older adults.
   a. True
   b. False

10. Shame, family or staff attitude, and misperceptions are all examples of barriers to pain identification and management.
   a. True
   b. False